TCR Form Instructions 12/10/10

1. Date of Admission – Original admission date to this facility
2. Referral Date - date the N.F. received a request from the resident to speak to someone about the possibility of returning to the community (send to DOM within 10 business days)
3. Referred By- Name of person completing and submitting form , their phone number and email address
4. Facility Name- the Resident is currently there
5. Resident Name, DOB --/--/---- - and identifying information if they have Medicaid, Medicare or SS
6. Contact Name - of significant other, guardian, or legally authorized representative, phone number and relationship
7. County of Resident's transition - to aid in referral selection
8. Mark the box for services - that the Resident will need at home or specify any other needs
9. Based on Medicaid Waiver criteria - if resident has Medicaid, check which of these programs they would qualify for or list any previous waiver services
10. Print Form then Submit by Email - after completing the form you may print it for your records then click submit button at bottom of form to send to DOM. If you have problems with submission, please notify DOM at 1-800-421-2408 Long Term Care.

This section for DOM use

This section for Referral Agency or Organization

9. Agency name – agency that contacts the resident within 5 days of receiving this form
10. The disposition determination – a brief summary to be returned to DOM by the 16th business day of receipt of referral
11. Name of Contact - Agency personnel handling the referral
12. Date - final disposition determination is returned to DOM
13. save your entry by clicking the save button at bottom of form. Print a copy for your Records then return the form (link) by email to TCR@medicaid.ms.gov